

Must be received by the Benefits
Department within 31 days of the
qualifying event.

Press Tab to begin filling out the form.

SANDIA NATIONAL LABORATORIES

DENTAL & VISION CARE PLAN DISENROLLMENT FORM

Name (Last, First, Middle Initial)			Social Security Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Business Phone Number	Home Phone Number

Dependents to be disenrolled
☐ **Dental** ☐ **Vision**

						FOR BENEFITS USE ONLY	
Spouse's Name		Sex M/F	Birth Date	Social Security Number		Effective Date	Cancel Date
Dependent(s) Name(s)	Relationship to Employee***	Sex M/F	Birth Date	Social Security Number		Effective Date	Cancel Date

Reason for Dependent Disenrollment _____
Effective Date _____

SNL Database Updated _____
Metlife-Dental Notified _____
MoO-Vision Notified _____

Employee Signature Date

Sandia National Laboratories
ATTN: BENEFITS ELIGIBILITY DESK
PO Box 5800 MS 1022
Albuquerque, NM 87185